PROTECTIVE RESPONSES TO TRAUMA

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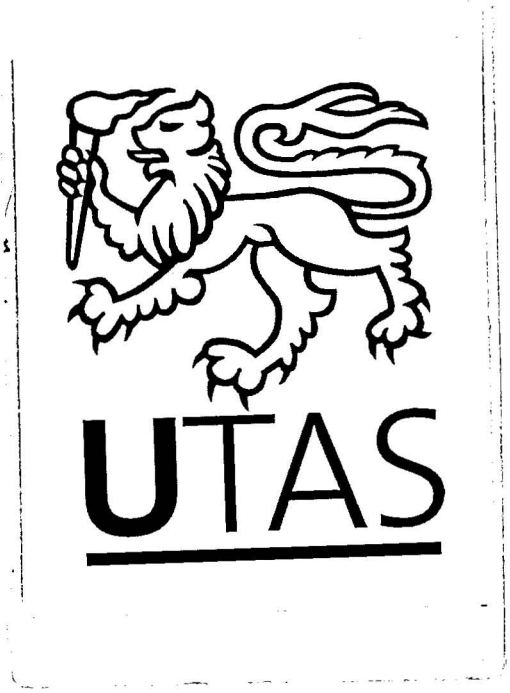

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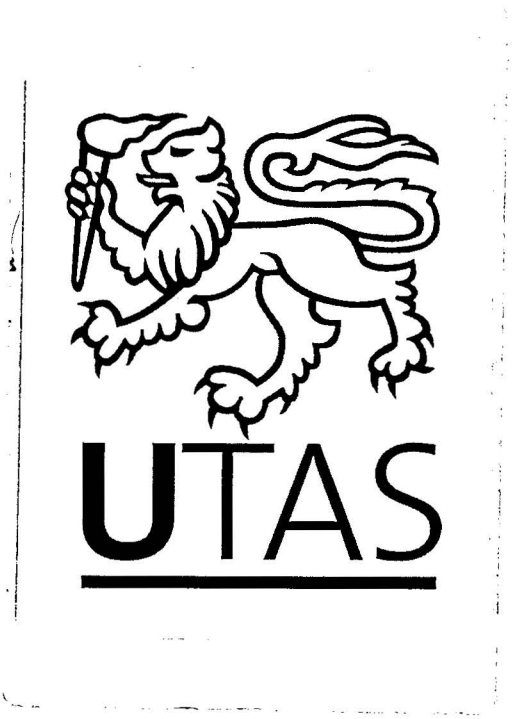
VOLUME 1



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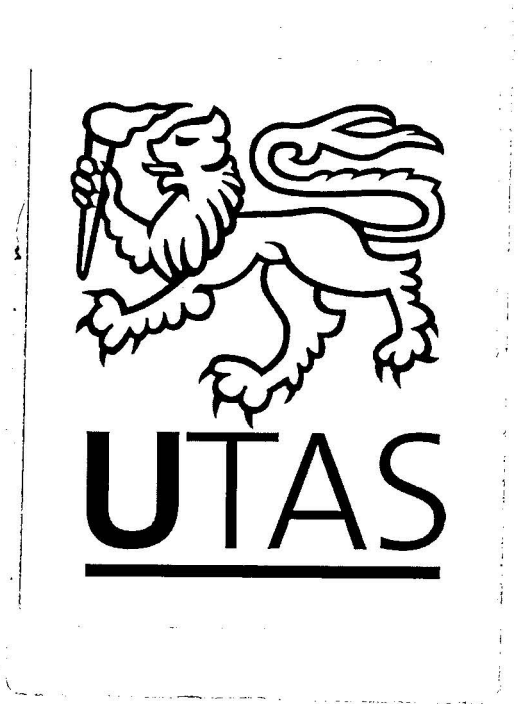

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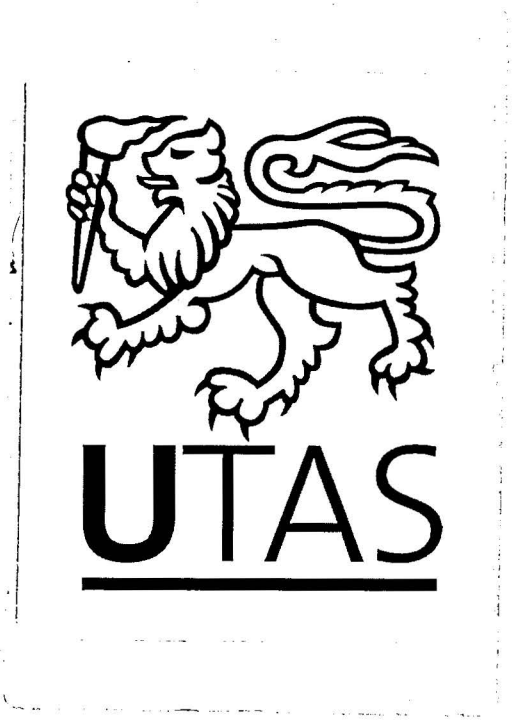

ABSTRACT

Research has indicated multiple factors unique to the individual may be more important in predicting their response to a traumatic event than objective assessment of the severity of an event. Such factors have included individual appraisal of threat to life and fear of death, emotional processing of the experience, perceived severity of the stressor, and perceptions of blame for the event. The current research aimed to systematically examine the contribution of such factors in the aetiology of posttraumatic stress responses and to consider factors that might influence the development of both positive and negative responses.

The integrative model proposed by Joseph, Williams and Yule (1995) provided structure to the investigation. The components included appraisal factors (the explanations formed for the event); stimulus factors (characteristics that rendered it most traumatic); personality factors (e.g., dysfunctional beliefs, attributional style, locus of control, anger expression and hostility); emotional state factors (peritraumatic emotional states, psychophysiological responses and dissociation); and activity factors (cognitive or behavioural actions taken after the event).

Eight studies based on evaluating each of these factors were conducted. The studies involved participants with Posttraumatic Stress Disorder (PTSD) (n=19), Acute Stress Disorder (ASD) (n=13), Sub-Clinical symptoms (n=17) and No symptoms (n=18). Comparisons across two event types; Motor Vehicle Accident (MVA) and Physical assault and two blame types; self-blame and other-blame were also made. The methodologies included clinical interview, questionnaire and a four stage guided imagery methodology to access psychological and psychophysiological states during imagery of the traumatic event.

These studies contributed to the current understanding of trauma responses by highlighting that a more vulnerable response to trauma was associated with more blame towards others, a perception of malicious intent to harm, less control, greater perceptions of life threat and peritraumatic fear of death and higher perceptions of the severity of the event, the threat to life and injury. Vulnerability was associated with greater irrational belief and social withdrawal. Although posttraumatic growth was observed in the PTSD group, a greater degree of negative changes were also observed. A more protective response to trauma, as observed in the ASD group who recovered within 4 weeks of the traumatic event, was associated with delay in attribution of blame until after the event, self-blame or blame towards others that was coupled with low perceptions of life threat and fear of death, lower severity ratings, lower levels of injury, and an absence of a trauma history. The Sub-Clinical group tended to blame their behaviour; to feel guilty and to criticise themselves more strongly than other groups but they may have been protected from developing full PTSD by the fact that they did not direct blame externally.

The results of the empirical studies contributed to the current understanding of protective responses to trauma and supported the role of the components of the integrative model (Joseph, Williams et al., 1995) in the aetiology of posttraumatic stress responses. The implications of these results for assessment, diagnosis and treatment of posttraumatic stress symptoms and directions for future research were discussed.

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